Updated 04/2013

Alabama Department of Mental Health
Office of Deaf Services

Notification of Right to Free Language Assistance

(This form must be presented in a format the consumer can easily understand. This usually means the consumers preferred language)

Verbiage should not be changed below this line.

I, _____, have been informed that it is important for my care to receive the services in the language that I understand best (my language of preference) and/or in a communication modality which is most readily understandable. I have been advised that the Department of Mental Health (DMH) is willing and can provide, at no cost to me, a clinical service provider who is fluent in my language of preference, a qualified professional interpreter or appropriate accommodations. I have decided:

☐ I want to work with a clinical service provider fluent in my language of preference for direct clinical services. I understand that a qualified interpreter may be utilized when a clinical service provider fluent in my language of preference is not available.

☐ I want to work with a qualified interpreter.

☐ I prefer to use the following person to interpret for me: _____. I agree not to hold my clinical service providers, ADMH or its contract programs responsible for any adverse results that may arise from using this person as my interpreter. (This person cannot be a family member or other person younger than 18 years old.)

☐ I am a hard of hearing or a deaf person and want to work with a clinical service provider utilizing the following accommodations (***please specify below****):

☐ Oral Transliterater ☐ Cued Speech Transliterater

☐ Written English, which may include the following methods (CART, C-print, typed via computer, Ubi-Duo, voice recognition software, handwritten notes, access to written materials, etc.)

☐ Lip reading/speechreading/residual hearing with the following accommodations (preferential seating, maintained eye contact, reduced ambient noises, speech directed to better ear, increased volume, appropriate turn taking and identification of speaker, etc.)

***Please specify preferred accommodations as mentioned above_____**

☐ Other, please specify: _____

☐ I do not want free language/communication assistance provided by ADMH as mentioned above. I agree not to hold my clinical service provider or any other personnel at ADMH or its contract programs responsible for any adverse consequences that may arise as a result of my decision.

I understand that if my treatment team requests an accessibility accommodation provided by DMH, it will be provided for them. I also understand that I can change my mind at any time. This waiver will expire one (1) year from the date signed.

_____ Signature of Consumer

_____ Signature of Parent or Guardian (if applicable)

_____ Date

_____ Signature of Provider

_____ Signature of Staff or Interpreter fluent in preferred language of consumer. (if preferred language is not English)

Note: If the consumer has indicated that he or she does not wish to take advantage of free language assistance, this refusal is to be documented in writing. Every effort should be made to assure that the consumer fully understands his or her right to accessible communication in their language of preference through a clinical service provider, fluent in their preferred language, an interpreter or other appropriate assistance and that such assistance will be provided at no charge. Pursuant to Title VI requirements this document is to be filed in the consumer's permanent file and a copy given to the consumer.